DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445368	A. BUILDING _____ B. WING _____	07/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIMAN CARE & REHAB CENTER	240 HANNAH ROAD HARRIMAN, TN 37748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #31855 were completed on July 31, 2013, at Harriman Health and Rehab Center. No deficiencies were cited related to complaint investigation #31855 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000	Harriman Care & Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on facility policy review and interview, the facility failed to accommodate the preferences of two residents (#72, #51) of thirty-nine residents reviewed. The findings included: Resident #72 was admitted to the facility on January 18, 2007, with diagnoses including Difficulty Walking, Dysuria, Anemia, Diabetes, Hypertension, Dementia, Seizures, and Contracture of the Joint. Review of facility policy, Dining Room, not dated revealed "...Residents will be encouraged to eat in the Dining Room..."	F 246		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 8/15/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 Review of facility policy, New Fine Dining Plan, not dated revealed "...Breakfast will continue...in the dining room from 7:00-7:30 am..." Interview in the resident's room on July 30, 2013, at 8:09 a.m., revealed "...they got me up at 6 o'clock this morning...I got dressed to go to the dining room...and then they told me it was too late to go...I was there at 7:20...I am very upset about it...told me I had to eat in my room...brought my tray in here...I don't want to eat in my room...they told me and (resident #51) we couldn't come in the dining room...you need to talk to (them)...upset about it too..." Interview with Certified Nursing Assistant (CNA) #1, on July 30, 2013, at 8:26 a.m., outside room 308 revealed "...we took two of the them (residents) to the dining room at 7:20 and we have until 7:30 to get them there...they told us it was too late to bring them in...breakfast trays were sent to their rooms...they were really upset..." Resident #51 was admitted to the facility on August 31, 2010, with diagnoses including Secondary Parkinsonism, Coronary Atherosclerosis, Hypertension, Diabetes, and Muscle Weakness. Interview in the resident's room on July 30, 2013, at 2:37 p.m., revealed "...I went to the dining room around 7:25 this morning...one of the staff who doesn't normally work in there told me it was too late and my tray was sent to the hall...the whole point of getting up early is to get there...did not give us an explanation...I assume they thought I was too late...I understand rules and	F 246	F – 246 Reasonable Accommodation of Needs/Preferences 1. The morning dining room staff was in-serviced immediately on 7/30/13 by the administrator re. there was no "cut off" time for residents to come to dining room for meals. The administrator advised Resident #51 and #72 of the corrective action on 7/30/13 and both voiced satisfaction. 2. Residents have the potential to be affected. 3. All nursing staff and department managers in-serviced by the Director of Nursing or Designee that residents may come in the dining area for meals at any time. Audits for the main dining room meals will be completed weekly for 4 weeks to assure all residents are provided their meal in the dining room at the time they choose to come in. 4. Audit findings will be reported by the DON or Designee to the QA/PI committee monthly (Quality Assurance committee consists of/ minimally: Administrator, DON, physician, Chaplain, Unit Mgrs. and	9-1-13

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F 246	Continued From page 2 regulations...but I wasn't late...I talked to the head nurse (Director of Nursing) about it...I told her what happened...said...would look into it...the Administrator came in and talked to me about it...apoligized...said it would not happen again...I believe (Administrator) always does what (Administrator) says...the person that made us leave was like a sergeant person...had an attitude of I am going to tell you what to do, we aren't in the army..." Interview with the Administrator on July 31, 2013, at 8:05 a.m., in the conference room confirmed "...two residents were turned away from the dining room by a Nurse who was helping out...I have talked with both residents and have explained to them they can be in the dining room any time...they will not be turned away again from the dining room...staff have been instructed that residents can come in the dining room at any time and no one is to be turned away..."	F 246	Social Services). Next Quality Assurance meeting scheduled for August 21st, 2013. Quality Assurance Committee will Review, discuss and make any necessary revisions or recommendations. F– 253 Housekeeping & Maintenance Services 1. On 12\27\2012 Quality Plumbing Company ran a sewer camera and recommended drain lines to be cleared of grease and to raise vent pipes on the roof. Both procedures were completed by January 2013.	9-13-13
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clean comfortable environment. The findings included: Observations of the facility on July 29, July 30,	F 253	2. Residents have the potential to be affected. 3. Plumbing company contacted by the Maintenance Director 8/14/13 to conduct another overall test and investigation on the plumbing system to determine if problem with odor is due to cracked or broken plumbing. Maintenance Director will complete audits weekly for 4 weeks after the plumbing testing and recommendations from investigation are completed to determine if odors resolve.	

9/9/13 Spoke with Karen Kirby
re. F-253 Tag States We
do not have to apply for
an extension - only have
to put date that prob.
was discovered & what plan is.

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F 253	Continued From page 3 and July 31, 2013, revealed a continuous strong foul odor noticeable throughout the facility. Interview with the Administrator, in the Administrator's office, at 1:30 p.m., on July 31, 2013, confirmed the facility had recurring strong odors, of unknown origin, throughout the facility since December 2012.	F 253	4. Plumbing Company test findings any recommendations and audits will be reported by Maintenance Director to the Quality Assurance committee monthly (Quality Assurance committee consists of minimally: Administrator, DON, physician, Chaplain, Unit Mgrs. and Social Services). Next Quality Assurance meeting scheduled for August 21st, 2013. Quality Assurance Committee will Review, discuss and make any necessary revisions or recommendations.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store foods under sanitary conditions. The findings included: Observation in the kitchen dry storage area on July 29, 2013, at 9:15 a.m., revealed three clear plastic bags of tortilla chips labeled August 24, 2012, stored and available for resident use. Continued observation revealed a clear plastic bin with thirty six foil packages of instant coffee with loose coffee grounds present in the bottom of the bin.	F 371	F- 371 Food Procure, Store/Prepare/Serve-Sanitary 1. Tortilla chips were discarded immediately on 7\29\13 by Dietary Director. Current menus were reviewed by the Dietary Director to verify that the tortilla chips were not intended for resident use on 7\29\13. The plastic bin, where pre-packaged instant coffee is stored, was cleaned immediately, and all packages of coffee were checked for proper sealing on 7\29\13 by Dietary Staff. The dented can of baked beans was immediately placed in proper area marked "damaged/dented cans" and	9-1-13

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F 371	Continued From page 4 Continued observation in the canned food storage area on July 29, 2013, at 9:22 a.m., revealed one 115 ounce can of baked beans with a dent on the seam of the can, stored and available for resident use. Observation in the paper goods storage area on July 29, 2013, at 9:30 a.m., revealed an open package of paper napkins lying on the floor. Observation in the walk in freezer on July 29, 2013, at 9:35 a.m., revealed one box of frozen pop-sickles stored open, undated, and available for resident use. Interview with the Dietary Manager on July 29, 2013, at 10:05 a.m., in the dietary department confirmed the tortilla chips were out of date, the dented can was improperly stored and available for use, napkins were to be stored with packages closed, off the floor, and the pop-sickles were not labeled, dated, and were available for use.	F 371	entire can storage was checked by Dietary Staff to verify that there were no other dented cans on 7\29\13. Paper napkins were immediately thrown away, floor was swept and mopped and the storage closet was rearranged to prevent napkins from falling in the corner between the 2 shelves on 7\29\13. The popsicles were immediately disposed of and the entire freezer was checked by the Dietary Staff for any open, undated items on 7\29\13. Immediate dietary staff in-service was completed by the Dietary Director\Designee re. proper food storage on 7\29\13. A 100% audit was completed 7\29\13 by the Dietary Staff to assure proper food storage.	
F 372 SS=D	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and dispose of refuse properly. The findings included: Observation in the dumpster area on July 29, 2013, at 9:50 a.m., revealed fourteen used vinyl	F 372	2. Residents have the potential to be affected. 3. All dietary staff in-serviced by the Dietary Director/Designee re. proper food storage. Audit for proper food storage to be completed by the Dietary Director/Designee weekly for 8 weeks.	

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F 372	Continued From page 5 gloves lying on the ground outside the dumpsters. Continued observation revealed two steel fifty gallon drums of used kitchen grease, both partially filled, with the closure rings lying on the ground at the base of the barrels and the lids unsealed. Interview with the Dietary Manager on July 29, 2013, at 10:05 a.m., in the dietary department confirmed the refuse was not disposed of properly and the grease barrels were to be sealed.	F 372	4. Audit findings will be reported by the Dietary Director/ Designee to the Quality Assurance committee monthly (Quality Assurance committee consists of minimally: Administrator, DON, physician, Chaplain, Unit Mgrs. and Social Services). Next Quality Assurance meeting scheduled for August 21st, 2013. Quality Assurance Committee will Review, discuss and make any necessary revisions or recommendations.	9.1.13
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F-372 Dispose Garbage & Refuse Properly 1. Grounds outside the dumpsters immediately cleaned by maintenance staff on 7\29\13. The 2 steel fifty gallon drums of used kitchen grease	9-1-13

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F 441	Continued From page 6 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to follow their policy on Handwashing. The findings included: Observation in the resident's main dining room on July 29, 2013, at 12:10 p.m., revealed five staff members handing out lunch trays and touching the residents without wearing gloves or washing hands. Continued observation revealed this occurred for fourteen of twenty-six residents observed. Review of facility policy, Handwashing, last revised December 2010 revealed "...appropriate times for staff to wash hands...before handling a resident's food or food tray..." Interview with the Director of Nursing (DON), on July 29, 2013, at 12:15 p.m., in the 400 hallway confirmed hands must be washed prior to touching a resident's food or food tray and when	F 441	were immediately sealed by the maintenance staff on 7\29\13. 2. Residents have the potential to be affected. 3. All staff in-serviced by the Staff Development Coordinator, Dietary Director and/or Designee re. proper disposal of garbage at the dumpster area. All dietary staff in-serviced by the Dietary Director/Designee re. proper sealing of the grease barrels at all times. Audit to be completed by the Dietary Director/Designee of the dumpster area for garbage on the grounds and to verify grease barrels are properly sealed daily for 2 weeks then weekly for 6 weeks. 4. Audit findings will be reported by the Dietary Director/ Designee to the Quality Assurance committee monthly (Quality Assurance committee consists of minimally: Administrator, DON, physician, Chaplain, Unit Mgrs. and Social Services). Next Quality Assurance meeting scheduled for August 21st, 2013. Quality Assurance Committee will Review, discuss and make any	

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F 441	Continued From page 7 contact had occurred with the resident. The DON confirmed facility policy had not been followed.	F 441	necessary revisions or recommendations.	
F S14 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to complete an admission assessment for one resident (#208) of thirty-nine residents reviewed. The findings included: Resident #208 was admitted to the facility on July 19, 2013, with diagnoses including Intracranial Hemorrhage, Dysphagia, Muscle Weakness, Diabetes, Chronic Pain, and Bipolar Disorder. Medical record review of Nursing Admission Information dated July 19, 2013, revealed "...oral status: natural teeth, broken teeth, caries,	F S14	F-441 Infection Control, Prevent Spread, Linens 1. Managers working in the main dining room at lunch time on 7\29\13 were immediately in-serviced by the Director of Nursing/Designee on 7\29\13. 2. Residents eating in the main dining room have the potential to be affected. 3. All nursing staff and department managers in-serviced by the Director of Nursing/Designee re. hand washing procedure during meal times. Audit of the food service in the main dining room to be completed by the Director of Nursing/Designee, 2 times weekly for 4 weeks to verify that proper hand washing procedures are followed during meal times. 4. Audit findings will be reported by the Director of Nursing/ Designee to the Quality Assurance committee monthly (Quality Assurance committee consists of/ minimally: Administrator, DON, physician,	9-1-13

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F 514	Continued From page 8 edentulous, dentures..." Continued review revealed the boxes indicating the resident's dental status was not marked. Review of facility policy, Initial Resident Assessment and Reassessment, dated December 2010 revealed "...each resident admitted to the facility shall receive a complete head-to-toe assessment..." Observation in the resident's room on July 31, 2013, at 12:10 p.m., revealed the resident had decayed, broken, and missing upper and lower teeth. Interview with the resident revealed "...my teeth have been like this for over three years..." Interview with Licensed Practical Nurse (LPN) #1 on July 31, 2013, at 12:15 p.m., outside the resident's room, confirmed the resident "...has lots of dental issues..." Further interview confirmed "...I would not consider the admission assessment to be complete..."	F 514	Chaplain, Unit Mgrs. and Social Services). Next Quality Assurance meeting scheduled for August 21st, 2013. Quality Assurance Committee will Review, discuss and make any necessary revisions or recommendations. F-514 Res Records-Complete/Accurate/Accessible 1. Dental assessment for Resident #208 was completed on 7-31-13 with dental referral made. 2. Residents have the potential to be affected. 3. 100% audit of all new admissions for the past 30 days completed to ensure completion of admission packet to include dental status and referrals made as needed. Licensed nursing staff in-serviced on completion of the nursing admission packet to include dental status. 4. Audit findings will be reported by the Director of Nursing/ Designee to the Quality Assurance committee monthly (Quality Assurance committee consists of/ minimally: Administrator, DON, physician, Chaplain, Unit Mgrs. and Social Services). Next Quality Assurance meeting scheduled for August 21st, 2013. Quality Assurance Committee will Review, discuss and make any necessary revisions or recommendations.	9-1-13